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**BEFORE THE BOARD OF OSTEOPATHIC EXAMINERS
IN MEDICINE AND SURGERY**

In the Matter of:

**LYNN CURTIS SWEET, D.O.
Holder of License No. 3246**

**For the Practice of
Osteopathic Medicine
In the State of Arizona**

OAH No. 10A-DO-10-0001A-OST

Board No. DO-10-0001A

**FINDINGS OF FACT, CONCLUSIONS OF
LAW AND ORDER**

(Revocation of License)

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On January 22, 2011, this matter came before the Arizona Board of Osteopathic Examiners in Medicine and Surgery ("Board") for oral argument and consideration of the Administrative Law Judge ("ALJ") Sondra J. Vanella's proposed Findings of Fact and Conclusions of Law and Recommended Order. Dr. Lynn Sweet ("Respondent") was not present, nor was his legal counsel of record, James Marovich and Jeffrey Grass. Assistant Attorney General Camila Alarcon represented the State. Christopher Munns, Assistant Attorney General with the Solicitor General's Section of the Attorney General's Office, was available telephonically to provide independent legal advice to the Board.

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The Board, having considered the ALJ's decision and the entire record in this matter, adopts the Findings of Fact with modifications to Finding of Fact 40, changing T.H.'s prescription for Ambien from 1.5mg to 12.5 mg, (See Exhibit 5) and Finding of Fact 82, changing the date of the transcript from 10/10/10 to 10/19/10 (See Transcript page 475) and adding Paragraph 3 to the Order, assessing the cost of the formal hearing; and hereby issues the following Findings of Fact, Conclusions of Law and Order.

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FINDINGS OF FACT

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Procedural Background

1 1. The Arizona Board of Osteopathic Examiners in Medicine and Surgery (the "Board") is
2 the duly constituted authority for licensing and regulating the practice of osteopathic medicine
3 in the State of Arizona.

4 2. Lynn Curtis Sweet, D.O. is the holder of License No. 3246 for the practice of osteopathic
5 medicine in the State of Arizona.

6 3. On August 10, 2010, the Board issued Interim Findings of Fact, Conclusions of Law, and
7 Order for Summary Suspension of License under which the Board concluded that Dr. Sweet had
8 engaged in unprofessional conduct as defined in A.R.S. §§ 32-1854(6) (engaging in the practice
9 of medicine in a manner that harms or may harm a patient or that the Board determines falls
10 below the community standard), 32-1854(36) (prescribing or dispensing controlled substances
11 or prescription-only medications without establishing and maintaining adequate patient
12 records), 32-1854(38) (any conduct or practice that endangers a patient's or the public's health
13 or may reasonably be expected to do so), and 32-1854(44) (conduct that the Board determines
14 constitutes gross negligence, repeated negligence or negligence that results in harm or death
15 of a patient). The Board concluded that emergency action was required under A.R.S. § 32-
16 1855(C), and ordered that Dr. Sweet's license be summarily suspended.

17 4. On August 10, 2010, the Board issued a Notice of Hearing setting this matter for formal
18 administrative hearing before the Office of Administrative Hearings, an independent state
19 agency.

20 5. The hearing in this matter convened on September 7, 2010, with further hearing held
21 on September 8, October 18, and October 19, 2010.

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23 **The Board's Guidelines:**
24 **The Prescribing of Controlled Substances for the Treatment of Pain Management**

25 6. The Board has adopted the following guidelines when evaluating the use of controlled
26 substances for pain control:

27 1. Pain Assessment:

28 A. Medical History

29 A comprehensive history should include a review of pertinent lab and diagnostic
30 test[s] that have already been performed. The initial evaluation of the pain

1 complaint should include characteristics such as intensity, character, frequency,
2 location, duration, and precipitating and relieving factors, underlying or co-
existing diseases or conditions.

3 It should also include a thorough analgesic medication history, including current
4 and previous prescription medications, over-the-counter medications, natural
remedies and illicit drug use.

5 It should also include an evaluation of physical function. This should focus on
6 pain associated disabilities, including activities of daily living.

7 2. Treatment Plan:

8 A. Pain Relief

9 A treatment plan should be developed for the management of chronic pain.
10 Consideration should also be given to different treatment modalities, such as a
11 formal pain rehabilitation program, the use of behavioral strategies, the use of
12 non-invasive techniques, or the use of medications. The assessment of pain
13 should occur, not only during the initial exam, but also after each new reportive
pain, at the appropriate intervals, after each pharmacological intervention and
at regular intervals during treatment.

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16 3. Informed Consent:

17 Advise the chronic pain patient or guardian of the risks and the benefits of the
18 use of controlled substances as well as alternatives to that treatment. They
19 should be counseled on the importance of regular visits, the impact of
20 recreational drug use, avoiding the use of multiple pharmacies and physicians
for prescriptions and taking medication as directed. A contract should be signed
outlining the patient's responsibilities, if appropriate.

21 4. On-going Assessment:

22 Patients with chronic pain should be re-assessed regularly. The frequency of
23 follow-up should be a function of the pain syndrome and potential for adverse
24 effects of treatment. The physician may consider discontinuing the use or
25 modifying medications if the patient is experiencing side effects that are not
tolerable, if clinical improvement does not occur, or if the physician notes non-
compliance. The clinician should watch for signs of narcotic use for
inappropriate indications like anxiety or depression.

26 Requests for early refills should prompt an evaluation of tolerance to the
27 medication, progression of disease or inappropriate behavioral factors.

28 5. Consultation and Referral - Optimal Treatment requires a team approach:

29 Psychiatrists, psychologists, pain management specialists are available and
30 should be part of the treatment team specifically in the more complex patient.

6. Documentation:

Documentation is essential for supporting the evaluation. The clinician should include the reason for prescribing controlled substances. The clinician should also document the overall pain management treatment plan, any consultations received, and a periodic review of the status of the patient. The clinician should also include medications and treatments including the date, type, dosage and quantity prescribed.

7. Medical Record - in accordance with A.R.S. § 32-1800(2) and A.R.S. § 12-2291(4):

Physician should develop and maintain complete records to include:
Medical history and physical examination[;]
Diagnostic, therapeutic, and lab results;
Evaluations and consultations;
Treatment objectives;
Discussion of risks and benefits;
Treatment;
Medication (include date, type, dose and quantity)[;]
Instructions and agreements; and
Periodic reviews

Hearing Evidence

7. Dr. Sweet has held a license to practice osteopathic medicine in the State of Arizona since 1997. At the time of the Board's investigation, Dr. Sweet practiced as a family practice physician in Phoenix, Arizona. Dr. Sweet is not Board-certified in family medicine, nor is he Board-certified in pain management or psychiatry. Approximately 25% to 30% of Dr. Sweet's former patients were considered chronic pain patients.

8. On December 9, 2009, the Board received a complaint regarding Dr. Sweet's prescribing practices. The Board's investigator, John O'Hair Schattenberg, conducted an investigation of the complaint. Mr. Schattenberg authored an Investigative Report for the Board's review. See Exhibit 1. Mr. Schattenberg testified at hearing regarding his investigation and the findings contained in the Investigative Report and the Supplemental Reports thereto.

Investigative Report

9. Mr. Schattenberg testified that on December 9, 2009, he received an email from a reliable source at a law enforcement agency indicating that the source of the information he was about to receive was an employee of Citigroup who advised that there is a drug culture at

1 his place of employment that "was being fuelled (*sic*) by Dr. Sweet." See Exhibit 1. On
2 December 29, 2009, Mr. Schattenberg interviewed the source, patient R.H., who is referred to
3 as "Mr. X" in the Investigative Report. Mr. X was a former patient of Dr. Sweet. Mr. X was
4 referred to Dr. Sweet by co-workers at Citigroup. Mr. X told Mr. Schattenberg that employees
5 of Citigroup received Adderall, Soma, Xanax, Oxycontin, Oxycodone, Hydromorphone, and
6 other drugs. *Id.* Mr. X told Mr. Schattenberg that Dr. Sweet never did a complete examination
7 on him at any time. *Id.* Mr. X told Mr. Schattenberg that he was prescribed Opana ER 20mg,
8 Oxymorphone 10mg, Oxycontin, and Lidocaine patches in 20-day supplies and would have to
9 physically go to Dr. Sweet's office to obtain refills. *Id.* Mr. Schattenberg testified that Mr. X is
10 no longer a patient of Dr. Sweet because he was not happy with the care he received. Mr. X
11 told Dr. Sweet that he was becoming addicted to the drugs Dr. Sweet had been prescribing to
12 him, and Dr. Sweet did not address this concern. Also, Mr. X had gone to Dr. Sweet's office for
13 a scheduled appointment and was told that the appointment had been canceled and was not
14 given a reason for the cancellation. Mr. X expressed concern to Mr. Schattenberg about two of
15 Dr. Sweet's patients, A.P. and T.P., a husband and wife, both of whom had worked at Citigroup
16 and whom Mr. X said had been selling drugs at work. *Id.*

17 10. On December 30, 2009, Mr. Schattenberg conducted a query of the Arizona Pharmacy
18 Board's Prescription Monitoring Program database of Dr. Sweet's controlled substance
19 prescriptions written and filled between January 1, 2009 and December 27, 2009. *Id.* The
20 results of that query revealed that Dr. Sweet wrote 10,813 prescriptions for controlled
21 substances during that time frame. This query did not include the prescriptions written by the
22 physician's assistants and nurse practitioners who worked in Dr. Sweet's office. *Id.* Mr.
23 Schattenberg opined that this number of prescriptions in this timeframe was "extremely
24 excessive."

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26 11. On January 4, 2010, Mr. Schattenberg returned a phone call to Mr. X who informed Mr.
27 Schattenberg that A.P. had died in his sleep overnight between December 30, 2009 and
28 December 31, 2009. *Id.*

29 12. On January 4, 2010, Mr. Schattenberg received a call from Detective Tim Taylor of the
30 Phoenix Police Department regarding an unrelated drug case involving Dr. Sweet. *Id.* One of

1 Dr. Sweet's patients, T.H., had been arrested outside of Dr. Sweet's office for attempting to
2 obtain prescription drugs by fraud.

3 13. On January 4, 2010, Mr. X called Mr. Schattenberg to state that he had been advised by
4 one of his sources at Citigroup that another of Dr. Sweet's patients, M.M.R., had died
5 approximately one year ago in her home. *Id.*

6 14. On January 4, 2010, Mr. Schattenberg subpoenaed the medical records of patients R.H.,
7 A.P., T.P., T.H., J.R., and M.M.R., along with the records of another individual who had been
8 involved in T.H.'s attempt to obtain prescription drugs by fraud.

9 15. On January 6, 2010, Mr. X called Mr. Schattenberg to advise that his source at Citigroup
10 had told him that T.P. may have contributed to A.P.'s death. *Id.* Mr. X told Mr. Schattenberg
11 that A.P. had been "sending love messages to [an] ex-girlfriend on the internet." *Id.* Mr. X also
12 reported that T.P. had "altered the drug inventory at their home prior to calling the Tempe
13 Police upon discovering A.P.'s body." *Id.*

14 16. On January 11, 2010, Mr. X contacted Mr. Schattenberg to inform him that he had
15 heard from "someone who he described as very, very close to T.P., that she crushed up a huge
16 quantity of Opana and slipped it to A.P. in a drink the night he died." *Id.*

17 17. Mr. Schattenberg credibly testified regarding his involvement in the investigation, and
18 his gathering of the documentary evidence consisting of medical records, autopsy reports, and
19 police reports. Mr. Schattenberg acknowledged that the investigation was limited to the
20 patients named by the informant.

21 Medical Consultant's Report

22 18. Dr. Barbara Prah, D.O., the Board's Medical Consultant, reviewed the medical records
23 obtained from Dr. Sweet for patients A.P., M.M.R., T.H., T.P., J.R., and R.H. Dr. Prah has been a
24 medical consultant for the Board for ten years. Prior to becoming a medical consultant for the
25 Board, Dr. Prah was Board-certified in family practice and practiced medicine for 15 years. Dr.
26 Prah prepared a Report for the Board based upon her review of the medical records, the
27 autopsy reports, the pharmacy audits, and the police reports, and summarized her concerns
28 regarding Dr. Sweet's practices. Dr. Prah testified at hearing regarding her practice
29 background. Dr. Prah testified that the standard of care is generally what a reasonable
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1 physician practicing in the same area would do in a similar circumstance. Dr. Prah testified that
2 a pain management specialist receives specialized training in this area of medicine, such as
3 residencies in pain management, training regarding potential interactions with other drugs,
4 drug seeking behavior in patients, side effects, intentional and unintentional overdose, and
5 addiction.

6 19. Dr. Prah testified extensively and credibly regarding her review of Dr. Sweet's patients'
7 records and her conclusions concerning Dr. Sweet's unprofessional conduct as follows:

8 **Patient T.P.**

9 20. On March 17, 2008, T.P. had her first appointment with Dr. Sweet. T.P. had previously
10 seen other providers in Dr. Sweet's office, including Dr. Sweet's Nurse Practitioner ("N.P."),
11 Theresa Kelso. T.P. was 27 years old at the time of her first visit with Dr. Sweet. T.P.'s chief
12 complaint was chronic back pain. Dr. Sweet prescribed Norco (Hydrocodone) 10 mg #120 and
13 Xanax 0.5 mg #90 (a Benzodiazepine). However, there is no corresponding patient record for
14 T.P. on that date. Therefore, there is no evidence that Dr. Sweet conducted a physical exam on
15 that visit. Dr. Sweet did not obtain T.P.'s previous medical records.

16 21. On April 29, 2008, T.P. had her next visit with N.P. Kelso. N.P. Kelso prescribed Vicodin
17 (Hydrocodone) and Soma (a muscle relaxant). Dr. Prah testified that Soma is prescribed for
18 acute pain and muscle spasm in the short term.

19 22. On May 2, 2008, T.P. had an MRI of the lumbar spine performed.

20 23. On June 4, 2008, T.P. had her next appointment with N.P. Kelso. N.P. Kelso prescribed
21 Xanax, Soma, and Vicodin. On June 4, 2008, T.P. had an MRI of the thoracic spine.

22 24. T.P. continued to be seen in Dr. Sweet's office on a regular basis, usually once a month,
23 and obtained refills of her prescriptions at those visits.

24 25. In March 2009, T.P. signed a pain management contract agreeing to fill all of her
25 prescriptions exclusively at CVS pharmacies. That contract notwithstanding, Dr. Sweet allowed
26 T.P. to fill her prescriptions elsewhere. This approval was not contained in the notes in T.P.'s
27 records.
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29 26. On April 13, 2009, Dr. Sweet saw T.P. and refilled T.P.'s prescriptions for Percocet #150
30 and Zanaflex 4 mg #60. Dr. Sweet failed to perform a physical examination on T.P. on this date.

1 27. Between June 15, 2009, and August 31, 2009, T.P. was seen three times by Genevieve
2 Smith, P.A., in Dr. Sweet's office. Physical exams were not documented at any of these visits.
3 T.P.'s prescription for Percocet #150 was refilled at the first two visits, and increased to #200
4 on the August 31, 2009 visit. T.P.'s Xanax and Soma prescriptions were also refilled at these
5 visits.

6 28. Dr. Sweet did not refer T.P. to a pain management specialist notwithstanding her
7 diagnoses of chronic back pain, for which T.P. was placed on disability, hip pain, leg pain, and
8 migraines. Dr. Prah testified as to T.P.:

9 Her MRI was not very impressive. However, I have stated that you can't only go
10 by the MRI. You have to - - you have to understand that sometimes people have
11 pain that is not able to be documented by x-ray or MRI. However, she was not
12 sent to any specialist at any time, not - - no orthopedic surgeon, no spinal
13 specialist, no pain management specialist, no one to corroborate her - - Dr.
14 Sweet's findings and corroborate the fact that she was in such significant low
back pain that she needed relatively high doses of pain medication and was,
therefore, disabled.

15 Transcript 9/8/10 at 187.

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17 29. Dr. Prah expressed several concerns with Dr. Sweet's care of T.P., including the
18 following: i) there were several instances when T.P. had an appointment at Dr. Sweet's office
19 and did not receive a physical exam; one of these appointments was with Dr. Sweet; ii) Dr.
20 Sweet did not enforce his own pain management contract; iii) Dr. Sweet did not obtain T.P.'s
21 old medical records regarding her chronic back pain; iv) Dr. Sweet did not refer T.P. to an
22 appropriate specialist; v) Dr. Sweet did not require a urine analysis to confirm that T.P. was
23 taking her medications as directed; vi) T.P. was prescribed higher doses than expected of Xanax
24 and Percocet; and vii) blood work should have been ordered to ensure that T.P. had not
25 experienced any liver damage, as Percocet contains Tylenol. All of the medications prescribed
26 to T.P. are cleared through the liver and kidneys and can be dangerous to liver function. Dr.
27 Prah opined that blood tests should have been ordered to ensure that damage was not
28 occurring to T.P.'s organs. Dr. Prah expressed further concern regarding the fact that Dr. Sweet
29 was responsible for supervising his physician assistants, and P.A. Smith failed to perform
30 physical exams on several visits. Dr. Prah acknowledged that there is no requirement for urine

1 drug screens contained in the Guidelines, nor is there a requirement in the guidelines that a
2 physical exam be performed at every visit. Dr. Prah testified that the Guidelines do not specify
3 a requirement for a physical exam to be performed at every visit because the Board expects a
4 physical exam be conducted at every visit at least of the area of complaint. Dr. Prah testified
5 that this is the standard of care in the community. Dr. Prah further testified that if a physician
6 does not document the care a patient received, such as a physical exam, it is assumed that it
7 was not done. On cross-examination, Dr. Prah acknowledged that Dr. Sweet had referred T.P.
8 to a psychiatrist.

9 30. Dr. Sweet argued that primary care providers often treat chronic pain and a referral is
10 only warranted when a physician feels that a patient's condition is beyond the scope of their
11 practice.¹ Dr. Sweet contended that he successfully managed T.P.'s care for years and that he
12 cut T.P.'s pain medication use in half between January 29, 2010 and March 9, 2010. On May 5,
13 2009, Dr. Sweet referred T.P. to a psychiatrist because he was concerned about her depression.
14 Dr. Sweet also treated T.P. with trigger point injections to manage her pain. Dr. Sweet argued
15 that the Board's Guidelines do not require or recommend urine drug screens. See Exhibit 13.

16 31. In response to the Board's claim that Dr. Sweet failed to perform a physical exam on
17 April 13, 2009, Dr. Sweet contended that T.P.'s pain had improved, she was managing with less
18 medication, and was in for a refill. The topic for this visit was lowering her pain medication.

19 32. Regarding T.P.'s pain contract, Dr. Sweet asserted that the requirement to have a
20 patient fill prescriptions at only one pharmacy was meant as an attempt to monitor the
21 patient's narcotic medication use. However, in 2009, the Arizona Pharmacy Board offered an
22 online tool that allowed physicians to view all narcotic prescriptions filled statewide by the
23 patient. Therefore, Dr. Sweet argued that this technological innovation rendered the portion
24 of the pain management contract requiring the use of a single pharmacy obsolete.
25

26 **Patient J.R.**

27 33. J.R. was a 26 year old male who first became a patient of Dr. Sweet on September 16,
28 2009. J.R. made an appointment with Dr. Sweet because he was "having a lot of pain in [his]
29 lower and mid back" that he had been experiencing for several years. See Exhibit 7. Dr. Prah
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¹ The hearing evidence has been grouped by patient. Dr. Sweet's testimony will be included as relevant to the particular patients, and then more generally in a separate section.

1 testified that the examination of and history taken for J.R. were insufficient for a first visit. Dr.
2 Prah's Report indicates that "Dr. Sweet's exam was limited to the lumbosacral spine. His exam
3 noted that the patient had decreased range of motion and spasm on the right in the LS spine.
4 There is a check mark next to neuro marking that it was normal, otherwise no other exam was
5 performed." See Exhibit 2. J.R. had been to an urgent care clinic approximately two weeks
6 prior to his first appointment with Dr. Sweet. Dr. Sweet obtained the records from the urgent
7 care clinic. However, Dr. Sweet did not obtain any other medical records for J.R. The urgent
8 care records indicate under the heading, "Social History", that "there is a history of alcohol
9 use." Dr. Sweet did not address J.R.'s use of alcohol and prescribed him Oxycodone 15 mg
10 #120, notwithstanding that alcohol can potentiate Oxycodone, possibly resulting in patient
11 harm.

12 34. J.R. was seen by Dr. Sweet for three additional visits and each time his Oxycodone
13 prescription was refilled. The dosage was increased on the last two visits. J.R.'s medical
14 records do not reflect a progress note for his October 25, 2009 visit, when the dosage of
15 Oxycodone was increased. On November 18, 2009, Dr. Sweet referred J.R. to a chiropractor.

16 35. Dr. Prah's concerns regarding Dr. Sweet's care of J.R. include the fact that Dr. Sweet did
17 not order x-rays or any other tests regarding J.R.'s back pain, he did not obtain old medical
18 records with the exception of the records from the urgent care clinic, he did not require
19 confirmatory urine drug tests, and there were no laboratory tests obtained for J.R.

20 36. Dr. Sweet argued that he completed an exam and work up of J.R.'s back pain and tried
21 alternative treatments, including stretching exercises and trigger point injections. Dr. Sweet
22 requested that J.R. have an MRI performed. However, because J.R. was a cash pay patient, he
23 could not afford the procedure. Dr. Sweet contended that urine drug screens are not required
24 by the Board's Guidelines.

25
26 **Patient T.H.**

27 37. T.H. was first seen on April 16, 2009, by P.A. Smith. At that time, T.H. was 20 years old.
28 Dr. Sweet's office did not obtain any previous medical records for T.H. with the exception of an
29 emergency department record from Chandler Regional Medical Center dated June 19, 2008.
30 T.H. had been seen at the emergency room for left lower quadrant abdominal pain. The

1 emergency department records indicate that T.H. had stated that "she was in a lot of pain
2 when she was in jail this morning." See Exhibit 5. The emergency department records further
3 indicate that T.H.'s urine drug screen was positive for opiates and marijuana. *Id.* T.H.'s CT scan
4 showed a probable hemorrhagic cyst on the right ovary and some moderate free fluid in the
5 pelvis. *Id.* T.H. made an appointment with Dr. Sweet's office to obtain a refill of Oxycodone,
6 stating she was having calf pain due to an increase in her exercise regimen. P.A. Smith did not
7 perform a physical exam on T.H., but started her on Flector patches to apply to the affected
8 area for 12 hours and prescribed Oxycodone 15 mg #150.

9 38. On May 12, 2009, T.H. was seen by Dr. Sweet. The purpose of the visit was to obtain
10 prescription refills. However, she also complained of lower abdominal pain. Notwithstanding
11 such complaint, Dr. Sweet's exam was limited to the lumbosacral spine and noted that she had
12 a decreased range of motion. Dr. Sweet did not perform an abdominal exam. T.H. received a
13 prescription for Oxycodone 15 mg #150, a return to work note, and an order for an ultrasound
14 of her right breast. There was no mention in T.H.'s medical records of any issues with her right
15 breast.

16 39. On June 5, 2009, T.H. was seen by P.A. Smith. A physical exam was not documented.
17 T.H. received a refill of her prescription for Oxycodone.

18 40. On June 29, 2009, T.H. was seen by P.A. Smith. T.H. complained of insomnia and was
19 prescribed Ambien CR 12.5 and Oxycodone. T.H. signed a pain management contract at this
20 visit.

21 41. In July 2009, T.H. was seen by P.A. Smith. T.H. indicated that Ambien was not helping
22 with her insomnia and she was prescribed Restoril 30 mg #30. A pelvic ultrasound was ordered
23 to check on an ovarian cyst. However, no physical exam was conducted, including a pelvic
24 exam. T.H. received a refill of her Oxycodone prescription.

25 42. In August 2009, T.H. received a prescription refill for Oxycodone. However, there is no
26 office visit associated with this prescription.

27 43. In September 2009, T.H. was seen by Dr. Sweet for pain from her ovarian cyst and neck.
28 T.H. was given prescriptions for Valium 10 mg #90 and Oxycodone 15 mg #180.
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1 44. On October 10, 2009, Dr. Sweet ordered an x-ray of T.H.'s cervical spine. However,
2 T.H.'s chart does not contain any x-ray results.

3 45. On November 6, 2009, T.H. saw Dr. Sweet to obtain medication refills. Dr. Sweet did
4 not perform a physical examination of T.H. T.H. received a prescription for Oxycodone 15 mg
5 #200. On November 30, 2009, T.H. received another prescription for Oxycodone 15 mg #200.
6 T.H.'s patient record for this date indicates that "the pain has increased as she's started doing
7 this new physical therapy." See Exhibit 5. T.H.'s records do not contain any physical therapy
8 reports or notes.

9 46. On December 21, 2009, T.H. saw Dr. Sweet to request refills of her medications, stating
10 that her medications had been stolen. Dr. Sweet advised T.H. that she needed to obtain a
11 police report. However, Dr. Sweet gave T.H. prescriptions for Oxycodone 15 mg #150 and
12 Valium 10 mg #90. A urine drug screen was performed on T.H. It was positive for
13 benzodiazepines and Oxycodone. T.H. provided Dr. Sweet's office with a police report
14 regarding her stolen medications.

15 47. On December 30, 2009, T.H. was discharged from Dr. Sweet's practice after her arrest
16 outside of Dr. Sweet's office for attempting to obtain prescriptions by fraud. T.H. had gone to
17 Dr. Sweet's office with a male individual who was impersonating T.H.'s ex-boyfriend, J.R., in an
18 attempt to obtain prescriptions in J.R.'s name. The male individual was then planning on
19 selling the prescriptions to T.H.

20 48. Dr. Prah testified that Dr. Sweet's care of T.H. deviated from the standard of care
21 because a complete physical was never performed and at times no physical exam was
22 performed on the areas of complaint. Dr. Sweet did not order any work ups or laboratory
23 tests. Further, T.H.'s positive test for opiates and marijuana while at the emergency room
24 were not considered during the time she was under Dr. Sweet's care. Dr. Prah testified that
25 T.H. was subject to potential harm when her medications were increased without indication in
26 her records for the increase, and T.H. was prescribed relatively large doses of medications
27 without indication of whether they were actually necessary. The urine screen performed in Dr.
28 Sweet's office showed that T.H. was taking the medications. However, the urine screen does
29 not indicate the dosage that was being taken. As such, the potential for abuse existed.
30

1 Further, Dr. Sweet was responsible for P.A. Smith's care of T.H., and P.A. Smith failed to
2 perform physical exams.

3 49. Dr. Sweet contended that he performed a urine drug screen on T.H. and the results
4 were negative for marijuana and other illicit drugs, and positive for the prescribed medications.
5 T.H. was sent to Diamondback Physical Therapy on September 16, 2009. However, T.H. opted
6 to see a chiropractor instead. Cervical x-rays were ordered on October 10, 2009. T.H.
7 informed Dr. Sweet that the chiropractor took the x-rays and she would bring the records to
8 Dr. Sweet's office. However, T.H. was discharged from Dr. Sweet's practice approximately one
9 month after this discussion, subsequent to her arrest outside of his office. Therefore, T.H. did
10 not provide the records from her x-ray to Dr. Sweet.

11 50. Dr. Sweet acknowledged that he did not document a physical exam of T.H. on
12 November 6, 2009. Dr. Sweet contended that because he had a busy practice, it was possible
13 to occasionally overlook some documentation due to the fact that he utilized paper charts. Dr.
14 Sweet testified that if allowed to practice again, he would change to electronic records.

15 **Patient R.H.**

16 51. On June 25, 2009, R.H., a 31 year old male, began seeing Dr. Sweet for pain
17 management. R.H. had been in the military for 15 years and explained to Dr. Sweet that he
18 had endured "wear and tear" on his body. See Exhibit 8. R.H. was given a prescription for
19 Oxycodone 15 mg #100.

20 52. On July 14, 2009, R.H. was seen again in order to obtain a refill of his prescription. R.H.
21 signed a pain management contract on that date, as well.

22 53. On August 9, 2009, R.H. was seen again by Dr. Sweet for a medication refill. He was
23 prescribed Oxycodone 15 mg #180.

24 54. On August 26, 2009, R.H. was seen again requesting refills of the prescription for lower
25 back pain and pain in his knees. Dr. Sweet did not perform a physical exam on this date.
26 However, R.H. received a prescription for Opana ER 20 mg #60 and a refill prescription for
27 Oxycodone 15 mg #180.

28 55. On September 16, 2009, R.H. went to Dr. Sweet's office to request refills of the
29 Oxycodone and Opana ER "because he lost a few days worth of the Oxycodone and Opana in
30

1 an (*sic*) backpack." *Id.* R.H. further complained of pain in his Achilles tendon. *Id.* R.H. received
2 prescriptions for Opana ER 20 mg #60, Oxycodone 15 mg #180, and a Medrol dose pack.

3 56. On October 5, 2009, R.H. was seen again, requesting refills. R.H. received a
4 prescription for a Lidoderm patch #60 and an increase in his Oxycodone prescription from #180
5 to #240.

6 57. R.H. was seen again on October 28, 2009, to obtain refills, stating that he was
7 experiencing shoulder pain. R.H. received prescriptions for Oxycodone 15 mg #240 and Inderal
8 #90. There is no indication in R.H.'s records as to why Dr. Sweet prescribed Inderal.

9 58. On November 14, 2009, R.H. went to Dr. Sweet's office requesting the "2nd half of
10 refill." *Id.* R.H. received a prescription for Opana ER #60 and Oxycodone 15 mg #60. This was
11 R.H.'s last office visit to Dr. Sweet. Dr. Prah testified that although R.H. requested a "2nd half of
12 refill," he was not given half a prescription on his previous visit.

13 59. R.H.'s records contain an undated drug screen with positive results for opiates and
14 Oxycodone. There is also indication in the records that Dr. Sweet attempted to obtain R.H.'s
15 old medical records.

16 60. Dr. Prah testified that her concerns regarding Dr. Sweet's care of R.H. included the fact
17 that R.H.'s old medical records were not obtained, there were no laboratory tests performed
18 notwithstanding the fact that R.H. was taking relatively large doses of opioids for an extended
19 period of time, no work-up regarding R.H.'s complaint of pain, and no physical exam was
20 performed on August 26, 2009. Dr. Prah testified that if Dr. Sweet had given R.H. a full exam
21 on his first visit, he then could have examined only the areas of concern at subsequent visits.
22 Dr. Prah explained that the medications taken by R.H are processed through the liver and
23 kidneys, and that when patients are on such high doses, physicians should periodically check to
24 ensure that the medications are not causing harm to these organs. Dr. Prah testified that
25 these medications are addictive and physicians have a role in ensuring that patients do not
26 become addicted. Physicians also play a role in ensuring that patients do not divert drugs. Dr.
27 Prah opined that if patients are willing to endure a full work up, they are probably experiencing
28 pain, and would not likely be procuring drugs to divert them.
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1 61. Dr. Sweet testified that R.H. was being treated simultaneously at the Veterans'
2 Administration Hospital ("V.A."), but that he was not happy with the pain management
3 treatment he was receiving at the V.A. R.H.'s sole purpose in seeing Dr. Sweet was for
4 assistance with pain management. Dr. Sweet contended that he requested on multiple
5 occasions R.H.'s medical records from the V.A. Dr. Sweet further contended that some of the
6 records were obtained, including R.H.'s medication list and "the problem list with service
7 related percentages." Dr. Sweet asserted that there was no need for blood work on R.H.
8 Regarding x-rays and a work-up, Dr. Sweet discussed having R.H. undergo an MRI. R.H.
9 informed Dr. Sweet that he would prefer to have the MRI and other diagnostic testing
10 conducted through the V.A. because he would not be charged for the tests. Regarding the lack
11 of physical exam on August 26, 2009, Dr. Sweet contended that there was no need for an exam
12 on this date because R.H. had an exam two weeks prior. R.H. came in for a prescription refill
13 on that date. Dr. Sweet gave R.H. two non-narcotic treatments on that date, Voltaren Gel and
14 Lidoderm patches.

15 Deceased Patients

16 Patient A.P.

17 62. A.P. was first seen in Dr. Sweet's office by N.P. Laurie Frasca, on November 30, 2007.
18 A.P. was 26 years old and married to Patient T.P. A.P.'s Health History Questionnaire indicates
19 that A.P. had been diagnosed as bi-polar, manic depressive, and that in April 2007, he was
20 treated for a cut to the left forearm, receiving 17 stitches and placed on a psychiatric hold at a
21 hospital. A.P.'s Health History Questionnaire further indicates that A.P. was taking the
22 following medications: Lamictal, Prozac, Ambien, and Vistaril. A.P. complained of arthralgias,
23 abdominal pain, and acid reflux. A.P. received a prescription for Soma 350 mg #30 and
24 Protonix 40 mg. A.P. was asked to return for follow-up. A.P.'s records note that if his condition
25 did not improve, he would be referred to a gastrointestinal ("GI") specialist.

26
27 63. In December 2007, N.P. Frasca ordered a SMAC, CBC, and arthritis profile, all of which
28 were found to be normal.
29
30

1 64. On January 4, 2008, A.P. returned to N.P. Frasca complaining of chronic and constant
2 pain in his joints. N.P. Frasca referred A.P. to a rheumatologist and a GI specialist and
3 continued A.P. on Soma.

4 65. In February 2008, A.P. saw Dr. Sweet. A.P. continued to complain of joint pain. Dr.
5 Sweet drew a rheumatoid factor and a cocci titer, which were negative.

6 66. On April 7, 2008, A.P. had a chest x-ray.

7 67. On May 8, 2008, A.P. had an abdominal and pelvic ultrasound.

8 68. On June 18, 2008, A.P.'s wife called Dr. Sweet's office to state that A.P. had had two
9 seizures. Dr. Sweet's office advised her to take A.P. to the emergency room. Dr. Sweet did not
10 perform a work up regarding A.P.'s seizures and did not obtain the emergency room records.
11 The etiology of the seizures remains unclear.

12 69. On December 5, 2008, A.P.'s records reflect that he was taking Norco, Soma, and
13 Xanax. However, it is unclear as to when A.P. was started on pain medication because it is not
14 documented in his chart. Further, some of T.P.'s medical records were in A.P.'s chart.

15 70. On January 9, 2009, Dr. Sweet referred A.P. for a Sleep Study. The Sleep Study was
16 conducted on February 20, 2009. A.P. was diagnosed with Moderate Obstructive Sleep Apnea.

17 71. A.P. was seen approximately every month and given refills of his medications.
18 However, the medications prescribed to A.P. were not documented in the medical record. Dr.
19 Prah's Report indicates that it appears that as of 2009, A.P. was taking Xanax 2 mg #100,
20 Oxycodone #240, Soma #120, and Celexa #30 every month. See Exhibit 2. A.P. had been
21 diagnosed from November 30, 2007 through 2009 with sleep apnea, morbid obesity,
22 dyspepsia, anxiety, bipolar disorder, depression, fibromyalgia, chronic pain, Attention Deficit
23 Disorder ("ADD"), and back pain.

24 72. On April 13, 2009, A.P. requested medication refills stating that his Percocet was
25 stolen. Dr. Sweet's notes indicated that A.P. was given a medication warning.

26 73. On May 23, 2009, Dr. Sweet received a letter from CVS Pharmacy stating that there
27 was a concern that A.P. may be overusing Soma and Xanax. Dr. Sweet did not respond to the
28 letter.
29
30

1 74. On June 26, 2009, A.P. was prescribed Ritalin. However, A.P. was not diagnosed with
2 ADD until July 23, 2009.

3 75. A.P. was last seen in Dr. Sweet's office on December 28, 2009 for a medication refill.

4 76. On December 31, 2009, Dr. Sweet's staff was notified that A.P. had died in his sleep on
5 December 30, 2009. A.P.'s autopsy results revealed that he died of Oxycodone toxicity. See
6 Exhibit 3. The autopsy report also indicates that the general anesthetic, Etomidate, was
7 present in A.P.'s blood when he died. *Id.*

8 77. Dr. Prah testified that she had numerous concerns regarding Dr. Sweet's care of A.P.,
9 including the following: i) Dr. Sweet saw A.P. and failed to perform physical examinations on
10 February 13, 2008, February 20, 2008, February 27, 2008, June 4, 2008, and July 3, 2008; ii) A.P.
11 was on disability for depression and anxiety, the disability insurance forms for which Dr. Sweet
12 completed. Yet, there is no evidence in A.P.'s records that he was under the care of a
13 psychiatrist; iii) A.P. received prescriptions for Xanax and Ambien, notwithstanding that he had
14 been diagnosed with moderate sleep apnea; iv) A.P. was prescribed Ritalin despite the patient
15 record being devoid of symptoms in reference to the diagnosis of ADD; v) A.P. stated his
16 medications were stolen; vi) Dr. Sweet did not follow up on A.P.'s seizures and Dr. Sweet did
17 not obtain the emergency records for the seizures, the etiology of which remains unclear; vii)
18 A.P. was not referred to a psychiatrist, notwithstanding the facts that A.P. had a psychiatric
19 history including a 24 hour hold, diagnoses of bipolar disorder and depression, and was on
20 disability for depression and anxiety; viii) Dr. Sweet received a letter of concern from CVS
21 Pharmacy that A.P. was overusing Soma and Xanax, and Dr. Sweet did not respond thereto and
22 continued to prescribe those medications to A.P.; ix) there was no work up regarding A.P.'s
23 back pain and he was not referred to a specialist; x) A.P. was referred to a rheumatologist in
24 January 2008, and there is no consult in A.P.'s chart; xi) there were no urine drug screens
25 performed; xii) some of T.P.'s medical records were contained within A.P.'s medical record; and
26 xiii) A.P. died of an Oxycodone overdose. Dr. Prah further testified that A.P. had been taking
27 Soma for longer than it is normally utilized, and that this is beyond the standard of care for use
28 of this drug. CVS Pharmacy sent a letter of concern in May 2009, and Soma was prescribed to
29 A.P. through November 2009. Dr. Prah testified that A.P.'s seizures were of special concern
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1 because seizures are very unusual, almost always indicate a serious concern, and A.P.'s patient
2 record is devoid of any information pertaining to the cause of the seizures. Dr. Prah testified
3 that the seizures could have been precipitated by a withdrawal of Xanax. Regarding A.P.'s
4 sleep apnea and the effect of the medications he was taking with regard to that condition, Dr.
5 Prah testified that Ambien and Xanax are central nervous system depressants, and that the
6 body's normal reaction of awakening might be inhibited by those drugs, especially given the
7 dose of Xanax that A.P. was taking daily.

8 78. Dr. Prah opined that Dr. Sweet contributed to A.P.'s death because he prescribed large
9 doses of Oxycodone to A.P. and A.P. died of a drug overdose. Dr. Prah acknowledged that the
10 Board did not consider the contribution of Etomidate or other contributing factors to A.P.'s
11 cause of death. However, the medical examiner felt A.P. died from an Oxycodone overdose,
12 and Dr. Prah characterized Dr. Sweet's prescribing of Oxycodone to A.P. as "cavalier" as there
13 was no indication for the need of this drug over a long period of time.

14 79. Dr. Prah opined that Dr. Sweet should have made a psychiatric referral for A.P. because
15 he requested to be placed on disability for depression and anxiety. Dr. Prah testified that a
16 family practitioner would normally want to refer a patient to a psychiatrist for this type of
17 determination, notwithstanding that family practitioners regularly treat patients for depression
18 and anxiety. Dr. Sweet made a recommendation to A.P.'s insurance company that he be
19 considered disabled due to his anxiety and depression. Dr. Prah opined that such
20 determination is beyond the scope of Dr. Sweet's practice.

21 80. Robert Zenner, M.D., a practicing psychiatrist for 20 years, testified on behalf of Dr.
22 Sweet. Dr. Zenner testified that he has known Dr. Sweet for 30 years, both personally and
23 professionally. Dr. Sweet has referred patients to Dr. Zenner. Dr. Zenner specifically testified
24 in regard to the Board's Interim Findings of Fact. Dr. Zenner testified that it is common
25 practice to prescribe multiple classes of medications, including prescribing more than one
26 benzodiazepine along with other classes of medications. Dr. Zenner explained that different
27 medications have different properties and that patients metabolize medications at different
28 rates. Therefore, it is common to combine medications in an effort to maintain a minimum
29 effective dose. Dr. Zenner testified that it is not contraindicated to prescribe benzodiazepines
30

1 and anti-depressants. However, when prescribing benzodiazepines, anti-depressants, and
2 narcotics, more care should be taken because "you have an additive or a compound effect as
3 far as the respiratory depression on the central nervous system." Transcript 10/19/10 at 469.
4 Dr. Zenner testified that he would be more comfortable in prescribing these combinations of
5 medications in the particular doses prescribed if the patient had been treated by the physician
6 for a long period of time.

7 81. Dr. Zenner testified that many family practitioners try to stabilize their patients on
8 psychiatric medications and if successful and comfortable with it, continue to do so. Dr. Zenner
9 testified that in extreme and acute situations, it would be appropriate to involve a psychiatrist.

10 82. Dr. Zenner testified that abruptly discontinuing Xanax could result in seizures, as well
11 as a number of other withdrawal symptoms. Dr. Zenner testified regarding Dr. Sweet having
12 prescribed both Ambien and Xanax to A.P., notwithstanding that A.P. had been diagnosed with
13 moderate sleep apnea. Dr. Zenner testified that the degree of sleep apnea will oftentimes be
14 used to determine what types of medications and the dosages that are safe to use. Dr. Zenner
15 further testified that "prescribing any kind of a central nervous system depressant has recently
16 become - - in combination with sleep apnea has come to the physician's attention more and
17 more over the recent couple of years." Transcript 10/19/10 at 475. Dr. Zenner opined that
18 Ambien is relatively safe in mild to moderate sleep apnea patients.

19 83. Regarding the CVS Pharmacy forms, Dr. Zenner testified that when he receives them,
20 he reads them, places them in the patients' charts, and responds to them by discussing them
21 with the patients. He then decides whether a medication change is warranted, and checks the
22 box referring to having a discussion with the patient. Dr. Zenner testified that these forms do
23 not guide his prescribing patterns.

24 84. Dr. Zenner testified about the prescribing of Ritalin. Dr. Zenner testified that Ritalin
25 can be prescribed for a number of conditions, such as Narcolepsy, excessive fatigue,
26 Fibromyalgia, Chronic Fatigue Syndrome, fatigue caused by Multiple Sclerosis, Primary
27 Hypersomnolence, Refractory Depression, or sleep apnea.

28 85. Dr. Zenner testified that he could not opine regarding the requirement of performing a
29 physical exam at every visit.
30

1 86. Dr. Zenner testified that he personally does not require his patients to perform
2 confirmatory urine analysis, but that he also does not generally prescribe narcotics.

3 87. Dr. Sweet testified that A.P. had been seeing a psychologist at the time he first came to
4 see him. Dr. Sweet acknowledged not having these medical records, did not know why they
5 were not in A.P.'s chart, and stated that it is a matter of course to request patient records. Dr.
6 Sweet testified that A.P. progressed to Percocet because of his pain and because multiple
7 modalities did not work for A.P. A.P. had received a trigger point injection, but because he was
8 needle averse, he received patches instead. A.P. had chronic back pain and chronic pain
9 throughout his body. After performing rheumatological blood work, wherein no markers were
10 positive, Dr. Sweet diagnosed A.P. with Fibromyalgia and Chronic Fatigue Syndrome and
11 ordered a sleep study. Dr. Sweet asserted that A.P. received many exams on his back and non-
12 narcotic treatments. Dr. Sweet contended that A.P.'s back pain was managed by medications
13 and other treatments.

14 88. Dr. Sweet acknowledged that A.P. received prescriptions for approximately 240 pills
15 per month, and that his wife, T.P., received a similar amount.

16 89. Dr. Sweet contended that A.P.'s claim of having his medications stolen was not
17 indicative of drug seeking behavior. A.P. had been Dr. Sweet's patient for approximately two
18 years when he reported to Dr. Sweet that his medications had been stolen. This was an
19 isolated incident and Dr. Sweet warned A.P. that he could be discharged from the practice in
20 the event this happened again. Further, A.P. had been a compliant, stable patient.

21 90. In February 2008, A.P. was seen in Dr. Sweet's office three times in a three week
22 period. On the first visit, he was seen for anxiety and arthralgias and blood work was ordered.
23 On the second visit, A.P. came in to complete paperwork for FMLA leave. The third visit was
24 for refills. Dr. Sweet asserted that in view of the reasons for A.P.'s visits, it was not
25 inappropriate to not perform physical exams on A.P. when he was seen three times in three
26 weeks in February 2008.

27 91. Regarding A.P.'s seizures on June 19, 2008, Dr. Sweet contended that T.P. was
28 instructed to take A.P. to the emergency room. Dr. Sweet ascertained from A.P. that he had
29 discontinued taking his Xanax. Dr. Sweet instructed A.P. not to abruptly stop his medications,
30

1 and that if he wished to cease taking Xanax, Dr. Sweet would counsel him on how to wean
2 himself off of the medication. A.P. elected to continue taking Xanax. Dr. Sweet did not obtain
3 the hospital records for A.P. because he had discussed the tests given at the hospital with A.P.
4 and felt he knew the reason for the seizures.

5 92. Regarding A.P.'s psychiatric history, Dr. Sweet contended that A.P.'s care was not
6 beyond the scope of his treatment, as A.P.'s condition was stable throughout his treatment by
7 Dr. Sweet and Dr. Sweet was comfortable managing his care.

8 93. Dr. Sweet asserted that he reviewed CVS's forms and the medications prescribed and
9 found them to be within a safe range. According to Dr. Sweet, A.P. was stable and
10 comfortable.

11 94. Dr. Sweet contended that A.P. was prescribed Ritalin for fatigue associated with
12 Fibromyalgia, not ADD.

13 95. Regarding the fact that some of T.P.'s medical records were contained in A.P.'s chart,
14 Dr. Sweet asserted that this was a clerical error.

15 96. Dr. Sweet asserted that he was in no way responsible for A.P.'s death for the following
16 reasons: i) A.P. had been stable on his medications, and if taken as prescribed, those
17 medications are safe and were well tolerated by A.P; ii) there was and still could be an open
18 homicide investigation into the cause of A.P.'s death; iii) there was a general anesthetic,
19 Etomidate, present in A.P.'s blood as revealed in the autopsy report; and iv) if A.P. were
20 unconscious, he would have been incapable of ingesting all the pills required for a fatal dose
21 (or any dose). Notwithstanding that Dr. Sweet prescribed to A.P. 2 mg of Xanax #100,
22 Oxycodone #240, Soma #120, and Celexa #30, Dr. Sweet contended that all of these
23 medications can be taken without contraindication. Dr. Sweet further testified that if taken as
24 prescribed, the medications were safe for A.P., as evidenced by the fact that A.P. was stable on
25 these medications for years.
26

27 **Patient M.M.R.**

28 97. M.M.R. was 27 years old when she was first seen in Dr. Sweet's practice by N.P. Frasca,
29 on January 20, 2006. M.M.R. disclosed that she had a seizure disorder and that her
30 medications were Prozac, Naprosyn, and Carbamazepine. See Exhibit 4, page 100. N.P. Frasca

1 diagnosed M.M.R. with insomnia, dysfunctional uterine bleeding, seizure disorder, depression,
2 and anxiety. N.P. Frasca prescribed Soma and Propranolol. *Id.* N.P. Frasca saw M.M.R. for a
3 few more visits between January 20, 2006 and October 6, 2006, when M.M.R. had an office
4 visit with N.P. Frasca and disclosed that she had a DUI and informed N.P. Frasca that the police
5 had taken away all of her medications. *See Exhibit 4, page 95.* At the time, M.M.R. was taking
6 Klonopin, Lexapro, Propranolol, Soma, and Carbamazepine. *Id.* N.P. Frasca instructed M.M.R.
7 to take all of her medications with food and to not drive or drink alcohol while taking muscle
8 relaxants. *Id.*

9 98. On December 15, 2006, M.M.R. returned to see N.P. Frasca, stating that she had fallen
10 in a parking lot at work and hurt her back. *See Exhibit 4, page 93.* N.P. Frasca prescribed
11 Percocet 5 mg #60. *Id.* In December 2006, M.M.R. signed a pain management contract.

12 99. On January 7, 2007, M.M.R. underwent a laminectomy and partial discectomy at Mercy
13 Gilbert Medical Center.

14 100. On January 17, 2007, M.M.R. was seen by N.P. Frasca for follow-up for her back
15 surgery. *See Exhibit 4, page 90.* She was prescribed Oxycodone 5/325 #240 and advised not to
16 drive or drink alcohol while taking her medications. *Id.*

17 101. On February 28, 2007, M.M.R. saw N.P. Frasca and informed her that she was jailed for
18 domestic violence. *See Exhibit 4, page 88.*

19 102. On April 16, 2007, M.M.R.'s brother called Dr. Sweet's office, advising that M.M.R. had
20 overdosed on Oxycontin.

21 103. On April 18, 2007, M.M.R. was admitted to a psychiatric unit for depression. *See*
22 *Exhibit 4, page 172.* The notes from the admission indicate that alcohol was involved. Dr.
23 Prah's Report indicates that M.M.R. listed her medications at admission as Protonix, Motrin,
24 Inderal, Zestril, Oxycodone, Valium, Lexapro, Lyrica, and Tegretol. *See Exhibit 2, page 7.* Laurie
25 Frasca was listed as her primary care provider. *See Exhibit 4, page 176.* The Discharge
26 Instructions note that M.M.R.'s medications were to be monitored by her primary care
27 provider, and that her primary care provider was to prescribe her medications. *Id.*

28 104. On April 20, 2007, M.M.R. was seen for follow-up by N.P. Frasca. N.P. Frasca's notes
29 indicate that M.M.R. had been suicidal but was feeling "more hopeful." *See Exhibit 4, page 87.*
30

1 N.P. Frasca gave M.M.R. refills on her prescriptions for Soma #30, Oxycodone #120, Cymbalta
2 #30, and Ativan 1 mg #60. *Id.*

3 105. On May 26, 2007, M.M.R. saw N.P. Frasca again. N.P. Frasca referred M.M.R. to a pain
4 management specialist for her back pain and a neurologist for her seizure disorder. *See Exhibit*
5 *4, page 85.* N.P. Frasca gave M.M.R. prescriptions for Oxycodone #120, Tegretol 200 mg #60,
6 and Seraquel 50 mg #60. *Id.*

7 106. On June 23, 2007, M.M.R. had an appointment with N.P. Frasca. Her prescription for
8 Oxycodone was increased to #240, and she was given a prescription for Xanax 0.5 #60. *See*
9 *Exhibit 4, page 84.*

10 107. In August 2007, M.M.R.'s brother contacted N.P. Frasca because he was upset about
11 the amount of medications M.M.R. was prescribed, and he wanted her providers to stop
12 prescribing to her.

13 108. M.M.R. continued to see N.P. Frasca until July 2008.

14 109. Dr. Prah's Report indicates that M.M.R. had an elevation in her liver enzymes that was
15 first noted in January 2006. The condition was followed by N.P. Frasca, and noted to be
16 elevated again in June 2007, and then significantly elevated in January 2008. *See Exhibit 2,*
17 *page 8.* There is no evidence that this condition was worked up or a referral made.

18 110. On August 26, 2008, Dr. Sweet assumed M.M.R.'s care. She was seen for refills of her
19 medications. Dr. Sweet did not perform a physical exam. M.M.R. was given a prescription for
20 Oxycodone 15 mg #60.

21 111. On September 26, 2008, M.M.R. saw Dr. Sweet again and was continued on Oxycodone
22 15 mg #60, Oxycontin 40 mg bid #60, and Xanax 1 mg #90 with two refills.

23 112. M.M.R. was last seen by Dr. Sweet on October 24, 2008. M.M.R.'s patient records
24 reflect that a neurologist had recently changed her seizure medication and that she had had
25 two seizures the previous week. *See Exhibit 4, page 55.* Dr. Sweet wrote M.M.R. prescriptions
26 for Oxycodone 15 mg #60 and Restoril 30 mg #30 with two refills.

27 113. On October 26, 2008, Dr. Sweet wrote M.M.R. a prescription for Zoloft 100 mg #60.

28 114. On November 19, 2008, M.M.R. was found deceased in her home. The autopsy report
29 lists sertraline (Zoloft) intoxication as M.M.R.'s cause of death. *See Exhibit 4.*
30

1 115. Dr. Prah had numerous concerns regarding N.P. Frasca's care of M.M.R. However, the
2 Arizona State Board of Nursing has jurisdiction over nurse practitioners and this matter does
3 not directly concern N.P. Frasca's care of patients, but rather Dr. Sweet's. Therefore, the
4 Administrative Law Judge does not address standard of care issues that pertain to N.P. Frasca
5 further herein. Dr. Prah expressed her concerns over Dr. Sweet's care of M.M.R. Dr. Prah
6 testified that Dr. Sweet should have considered managing M.M.R.'s case at an earlier time
7 given her complex medical and psychiatric history. Given that M.M.R. was such a complicated
8 case, Dr. Sweet should have considered having M.M.R.'s medications handled by a pain
9 management specialist or a psychiatrist. Further, Dr. Sweet did not follow up on M.M.R.'s
10 abnormal laboratories (elevated liver enzymes) once he assumed her care. Dr. Sweet did not
11 perform any confirmatory urine analysis.

12 116. Dr. Prah testified that she does not "blame" Dr. Sweet for M.M.R.'s death because had
13 she taken her medications as prescribed, those medications would not have caused her death.
14 However, Dr. Prah opined that there were many reasons to refer M.M.R. to a psychiatrist. Dr.
15 Prah opined that M.M.R. was not safe to treat or to continue on prescription medications
16 without psychiatric input. Dr. Prah testified that M.M.R. had previously overdosed and her
17 medical records indicated that she was not stable. M.M.R. was experiencing anxiety requiring
18 multiple medications. Dr. Prah opined that at no point in time in M.M.R.'s care could she say
19 that her treatment was appropriate. Dr. Prah testified that subsequent to M.M.R.'s initial
20 overdose, she was still prescribed medications and the change in dosage was minimal.

21 117. Dr. Sweet contended that he had no responsibility to supervise N.P. Frasca as she is a
22 licensed nurse practitioner and was hired as an independent contractor. Dr. Sweet further
23 contended that M.M.R.'s medication dosages were modified on multiple occasions, that urine
24 drug screens are not required by the Board, that M.M.R. was followed by a neurologist as of
25 May 2008, that referrals to pain management specialists were made on May 26, 2007,
26 November 29, 2007, January 30, 2008, February 27, 2008, and April 22, 2008, and that pain
27 management consult and treatment notes dated December 18, 2007 and January 9, 2008, are
28 contained in M.M.R.'s chart. See Exhibit 4. Further, Dr. Sweet asserted that M.M.R. was
29 referred to counseling for cognitive behavioral therapy on multiple occasions.
30

1 118. Dr. Sweet testified that M.M.R. committed suicide. The dosage of Zoloft prescribed to
2 her was a safe level, and she would have had to have been saving it for "quite a while" in order
3 to have enough for a lethal dose.

4 119. Dr. Sweet asserted in his written Closing Argument that the psychiatrists at Maricopa
5 Medical Center "validated the ongoing treatment of M.M.R. by recommending medication
6 monitoring and management to be continued to be carried out by the primary care physician."

7 **Dr. Sweet's Testimony**

8 120. Dr. Sweet testified that he has been practicing medicine since 1997. He has
9 participated in continuing medical education classes in psychiatry and performed extra
10 rotations in psychiatric residency. Dr. Sweet is a member of the chronic pain network. He has
11 not had any medical malpractice lawsuits filed against him, nor has he had any disciplinary
12 action taken against him regarding his hospital privileges.

13 121. Regarding physical exams, Dr. Sweet testified that his custom and practice will vary
14 depending on the presentation. Dr. Sweet "observes" his patients and examines the areas of
15 complaint. Dr. Sweet testified that he sometimes does not perform a physical exam if he has
16 recently seen a patient.

17 122. Dr. Sweet testified that he used to see between 25 and 30 patients per day, and that
18 his practice was open seven days a week. Dr. Sweet was open seven days a week because his
19 patients appreciated this service. Dr. Sweet testified that his practice saw approximately
20 12,045 patients per year, a majority of whom received prescriptions. Dr. Sweet, the nurse
21 practitioners, and the physician assistants all write prescriptions, and Dr. Sweet signs his
22 physician assistant prescriptions so that the patients can receive a month supply of their
23 medications rather than a two week supply. Dr. Sweet estimated that 25% to 30% of his
24 practice is pain management, both chronic and acute.

25 123. Dr. Sweet testified that he sometimes prescribes multiple benzodiazepines because
26 one might be used as a sleeping pill and one might be used during the day, and that sometimes
27 they are used with pain medications. However, Dr. Sweet testified that this is not the case for
28 the vast majority of patients. Dr. Sweet testified that these patients are monitored and re-
29 evaluated regularly. Dr. Sweet testified that in his chronic pain patients, dosages are increased
30

1 when the pain is not controlled and other modalities, like trigger point injections, do not work.
2 Dr. Sweet also explained that patients develop a tolerance to medications thereby requiring an
3 increase in dosage.

4 124. Dr. Sweet acknowledged that sometimes he is remiss and does not fill out paperwork
5 in patients' charts. Dr. Sweet testified that in the future he would utilize electronic medical
6 records because he would be alerted by the computer program if information was omitted
7 from his charts.

8 125. Regarding the CVS Pharmacy forms, Dr. Sweet testified that he reviews them to see if
9 the medications and dosages are appropriate and if his patients are receiving other
10 medications of which he is unaware. Dr. Sweet testified that there is no requirement under
11 the standard of care to respond to these forms.

12 126. Regarding his pain contracts, Dr. Sweet testified that the Pharmacy Board's technology
13 allows access to much better information, and in the event that his patients went to different
14 pharmacies than specified in the contracts, he could still monitor their medications.

15 127. Dr. Sweet testified that he previously did not require urine drug screens of his patients.
16 However, beginning in 2008, he began to require such tests, and expanded this practice in
17 2009. In 2010, urine drug screens became a regular part of a patient's office visit.

18 128. Regarding his treatment plans for patients, Dr. Sweet testified that his treatment plans
19 are "ongoing" and that chronic pain patients have chronic issues. Therefore, the treatment
20 plans are "living documents." Dr. Sweet acknowledged that the Board Guidelines require
21 certain information be incorporated into patients' treatment plans. Dr. Sweet contended that
22 pain relief is documented and that assessment of progress is also contained in the notes. Dr.
23 Sweet acknowledged that his notes "could stand to be improved." Dr. Sweet testified that he
24 always discusses with his patients the risks of long term use of narcotic medications.
25

26 129. Dr. Sweet ultimately acknowledged at hearing that pain management "is not for me"
27 and that it is a "vulnerability."

28 **Dr. Sweet's Prior Disciplinary History**

29 130. On September 24, 2009, the Board ordered Dr. Sweet to pay a civil penalty of \$250.00
30 based on a violation of A.R.S. § 32-1854(29), for "failing to allow properly authorized board

1 personnel to have, on presentation of a subpoena, access to any documents, reports of records
2 that are maintained by the physician and that relate to the physician's medical practice or
3 medically related activities . . ." See Exhibit 14A.

4 131. On March 31, 2010, the Board issued a Decree of Censure and imposed a two-year
5 probationary term upon Dr. Sweet having found that Dr. Sweet had "failed to maintain and
6 provide copies of medical records on a timely basis, and admitted he lost three patients'
7 records." See Exhibit 14B. The terms of probation ordered Dr. Sweet to complete 20 hours of
8 Continuing Medical Education and utilize a practice monitor. *Id.* The Board's Order gave Dr.
9 Sweet until March 31, 2011, to complete the Continuing Medical Education requirements. *Id.*
10 However, Dr. Sweet has not submitted courses to the Executive Director of the Board for
11 approval. The Board's Order provided that Dr. Sweet was to utilize a Board approved practice
12 monitor within 90 days of the Board's Order. *Id.* Dr. Sweet has not complied with this
13 provision of the Board's Order, notwithstanding the fact that he did not close his practice until
14 he was summarily suspended on August 10, 2010.

15 132. On September 3, 2010, the Board issued two Decrees of Censure to Dr. Sweet. One of
16 the Decrees of Censure was issued based upon Dr. Sweet's having deviated from the standard
17 of care by not "performing physical examinations, imaging and laboratory testing appropriate
18 to support an initial diagnosis, and in not periodically conducting appropriate follow up
19 examinations and testing to monitor the progress of a chronic condition." See Exhibit 14C. The
20 Board also found that Dr. Sweet "did not conduct the level of examination consistent with the
21 billing code used . . ." *Id.*

22 133. In the second Decree of Censure issued on September 3, 2010, the Board found that
23 Dr. Sweet had violated A.R.S. §§ 32-1854(6), (14), (26), and (38) when Dr. Sweet "deviated from
24 the standard of care in that he did not monitor the patient's condition during the years he
25 dispensed the medication to the patient; did not conduct the examinations or clinical
26 laboratory studies appropriate to the management of chronic hypertension and
27 cardiopulmonary disease; did not see the patient for timely follow up visits, did not refer the
28 patient for specialist consultations; nor did he take note if the patient was being seen by
29 another physician for any reason." See Exhibit 14D.
30

CONCLUSIONS OF LAW

1
2 1. In this proceeding, the Board bears the burden to prove, by a preponderance of the
3 evidence, that Dr. Sweet engaged in unprofessional conduct as defined in A.R.S. § 32-1854(6),
4 (36), (38), and/or (44), and that he is subject to disciplinary action pursuant to A.R.S. § 32-1855.
5 See A.A.C. R2-19-119.

6 2. A preponderance of the evidence is “such proof as convinces the trier of fact that the
7 contention is more probably true than not.” Morris K. Udall, ARIZONA LAW OF EVIDENCE § 5 (1960).

8 3. Pursuant to A.R.S. § 32-1854(6), unprofessional conduct includes “[e]ngaging in the
9 practice of medicine in a manner that harms or may harm a patient or that the board
10 determines falls below the community standard.” The Administrative Law Judge concludes,
11 based on the credible, probative, and substantial evidence of record, that Dr. Sweet engaged in
12 the practice of medicine in a manner that harms or may harm a patient or that falls below the
13 community standard. The evidence of record established that Dr. Sweet failed to perform
14 physical exams on several patients, failed to obtain medical records for several patients, failed
15 to perform laboratory tests and follow up on certain patients, and failed to refer complex
16 patients to appropriate specialists. Further, Dr. Sweet prescribed pain medications to patients
17 without first conducting complete physical examinations and diagnostic testing.

18 4. Pursuant to A.R.S. § 32-1854(36), unprofessional conduct includes “[p]rescribing or
19 dispensing controlled substances or prescription-only medications without establishing and
20 maintaining adequate patient records.” According to the Board’s Guidelines, physicians should
21 develop and maintain complete records to include: medical history and physical examination;
22 diagnostic, therapeutic, and lab results; evaluations and consultations; treatment objectives;
23 discussion of risks and benefits; treatment; medication (including date, type, dose and
24 quantity); instructions and agreements; and periodic reviews. The Administrative Law Judge
25 concludes, based on the credible, probative, and substantial evidence of record, including Dr.
26 Sweet’s own acknowledgements, that Dr. Sweet prescribed controlled substances to all of the
27 above-listed patients without establishing and maintaining adequate patient records.

28 5. Pursuant to A.R.S. § 32-1854(38), unprofessional conduct includes “[a]ny conduct or
29 practice that impairs the licensee’s ability to safely and skillfully practice medicine or that may
30

1 reasonably be expected to do so.” Notwithstanding the fact that the Board’s Guidelines do not
2 require urine drug screens, Dr. Sweet not only failed to perform such tests when appropriate,
3 but further failed to perform laboratory testing to determine how the patients who had been
4 taking pain medications and muscle relaxants for extended periods of time were responding to
5 the medications, and whether the medications were adversely impacting liver and kidney
6 function. Further, even when a patient, such as M.M.R., had laboratory work that indicated
7 elevated liver enzymes, Dr. Sweet did not address the abnormality. The Administrative Law
8 Judge concludes, based on the credible, probative, and substantial evidence of record, that Dr.
9 Sweet engaged in a practice that impaired his ability to safely and skillfully practice medicine.

10 6. Pursuant to A.R.S. § 32-1854(44), unprofessional conduct includes “[c]onduct that the
11 board determines constitutes gross negligence, repeated negligence or negligence that results
12 in harm or death of a patient.” Negligence is defined as “the failure to use such care as a
13 reasonably prudent and careful person would use under similar circumstances; it is the doing
14 of some act which a person of ordinary prudence would not have done under similar
15 circumstances or failure to do what a person of ordinary prudence would have done under
16 similar circumstances.” Black’s Law Dictionary 1032 (6th ed. 1990). Both A.P. and M.M.R. died
17 while under the care of Dr. Sweet. A.P. died of an Oxycodone overdose and M.M.R. committed
18 suicide via a sertraline overdose. Both of these individuals were complex patients receiving
19 large quantities of addictive medications for long periods of time. Both had complex mental
20 health issues. M.M.R. had unsuccessfully attempted suicide previously. Dr. Sweet failed to
21 fully address these patients’ mental health issues while under his care. Dr. Sweet sometimes
22 failed to conduct physical examinations of his patients, failed to perform work-ups, follow-up,
23 and failed to obtain patient records. The Administrative Law Judge concludes, based on the
24 credible, probative, and substantial evidence of record, that Dr. Sweet’s actions and omissions
25 in the care of his patients as documented in the above Findings of Fact constitute negligence
26 that resulted in harm or death of patients.

27
28 7. The Administrative Law Judge concludes, based on the evidence presented, and the
29 aggravating factor of prior disciplinary actions concerning similar circumstances, that the Board
30 sustained its burden of proof as to each of Dr. Sweet’s alleged violations of A.R.S. § 32-1854.

1 8. A.R.S. § 32-1855(l) provides:

2 A physician who, after an investigative or administrative hearing, is found
3 to be guilty of unprofessional conduct or is found to be mentally or
4 physically unable safely to engage in the practice of osteopathic
5 medicine is subject to any combination of censure, probation,
6 suspension of license, revocation of license, an order to return patient
7 fees, imposition of hearing costs, imposition of a civil penalty of not to
8 exceed five hundred dollars for each violation for a period of time, or
9 permanently, and under conditions the board deems appropriate for the
10 protection of the public health and safety and just in the circumstances.
The board may charge the costs of an investigative or administrative
hearing to the licensee if pursuant to that hearing the board determines
that the licensee violated this chapter or board rules.

11 9. Based on the foregoing statute, Dr. Sweet is subject to disciplinary action because he is
12 found to have engaged in unprofessional conduct based on his violations of A.R.S. § 32-
13 1854(6), (36), (38), and (44).

14 10. The State requested that Dr. Sweet's license be revoked. Based upon Dr. Sweet's
15 demonstrated violations of A.R.S. § 32-32-1854(6), (36), (38), and (44), and the serious nature
16 of those violations, as well as the aggravating factor of Dr. Sweet's prior discipline, the
17 Administrative Law Judge concludes that revocation of Dr. Sweet's license is the proper
18 disciplinary action.

19 **ORDER**

20 Based on the foregoing Findings of Fact and Conclusions of Law,

21 IT IS HEREBY ORDERED:

22 1. The Board's August 10, 2010 Order summarily suspending Dr. Sweet's license to
23 practice osteopathic medicine in the State of Arizona is affirmed.

24 2. Commencing on the effective date of the Order entered in this matter, Dr.
25 Sweet's license to practice osteopathic medicine in the State of Arizona (No. 3246) shall be
26 revoked.

27 3. Respondent is assessed the cost of formal hearing. Those costs shall be paid on
28 or about thirty-five (35) days from the date the Board issues an invoice for those costs, unless
29 that deadline is extended by the Board or Executive Director.
30

1 Copy of the foregoing sent via US Mail this 26th
2 day of January, 2011 to:

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14 Copies of the foregoing sent via electronic and interagency
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